SENATE BILL NO. 82

INTRODUCED BY B. KEENAN

BY REQUEST OF THE LEGISLATIVE FINANCE COMMITTEE

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE LAWS RELATING TO THE PUBLIC MENTAL HEALTH SYSTEM AND MANAGED CARE; CONSOLIDATING MANAGED HEALTH CARE ENTITY FINANCIAL SOLVENCY PROVISIONS UNDER THE ~~COMMISSIONER OF INSURANCE~~ DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; REDEFINING "MANAGED CARE COMMUNITY NETWORK"; REORGANIZING CERTAIN MENTAL HEALTH MANAGED CARE LAWS AND PUBLIC MENTAL HEALTH SYSTEM LAWS; PROVIDING A REQUIREMENT FOR A SYSTEM OF TRACKING CHILDREN WHO NEED MENTAL HEALTH SERVICES; REORGANIZING ELIGIBILITY FOR PUBLIC MENTAL HEALTH SERVICES; AMENDING SECTIONS 33-31-115, 53-6-116, 53-6-131, 53-6-701, 53-6-702, 53-6-703, 53-21-701, AND 53-21-702, MCA; AND REPEALING SECTION 53-21-704, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-31-115, MCA, is amended to read:

"33-31-115. Applicability to managed health care entity. (1) A managed health care entity, as defined in 53-6-702, is governed by the provisions of Title 53, chapter 6, part 7~~, and by the licensure and financial solvency provisions of this chapter, but the commissioner may by rule reduce or eliminate a requirement of this chapter if the requirement is demonstrated to be unnecessary for the operation of a managed health care entity~~.

(2) The department of public health and human services may limit the amount, scope, and duration of services provided by a managed health care entity under contract for programs established under Title 53. These services may be less than services required by this title."

Section 2. Section 53-6-116, MCA, is amended to read:

"53-6-116. Medicaid managed care -- capitated health care. (1) The department of public health and human services, in its discretion, may develop ~~managed care~~ managed care and capitated health care systems for medicaid recipients.

(2) The department may contract with one or more persons for the management of comprehensive physical health services and the management of comprehensive mental health services for medicaid recipients. The department may contract for the provision of these services by means of a fixed monetary or capitated amount ~~per~~ for each recipient.

(3) A ~~managed-care~~ managed care system is a program organized to serve the medical needs of medicaid recipients in an efficient and cost-effective manner by managing the receipt of medical services for a geographical or otherwise defined population of recipients through appropriate health care professionals.

(4) The provision of medicaid services through ~~managed-care~~ managed care and capitated health care systems is not subject to the limitations provided in ~~53-6-101 and~~ 53-6-104. The managed care or capitated health care system that is provided to a defined population of recipients may be based on one or more of the medical assistance services provided for in 53-6-101.

(5) The proposed systems, referred to in subsection (1), must be submitted to the legislative finance committee. The legislative finance committee shall review the proposed systems at its next regularly scheduled meeting and shall provide any comments concerning the proposed systems to the department ~~of public health and human services~~."

Section 3. Section 53-6-131, MCA, is amended to read:

"53-6-131. Eligibility requirements. (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of public health and human services, in its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq., and does not have income or resources in excess of the applicable medical assistance limits or receive from FAIM financial assistance, as defined in 53-4-702, benefits under Title IV of the federal Social Security Act, 42 U.S.C. 601, et seq.

(b) The person would be eligible for assistance under a program described in subsection (1)(a) if that person were to apply for that assistance.

(c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the person would be receiving assistance under one of the programs in subsection (1)(a).

(d) The person is under 19 years of age and meets the conditions of eligibility in the state plan,

as defined in 53-4-201, other than with respect to age and school attendance.

(e) The person is under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a child with special needs.

(f) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(e) and:

(i) the person's income does not exceed the income level specified for federally aided categories of assistance and the person's resources are within the resource standards of the federal supplemental security income program; or

(ii) the person, while having income greater than the medically needy income level specified for federally aided categories of assistance:

(A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the department the amount by which the person's income exceeds the medically needy income level specified for federally aided categories of assistance; and

(B) has resources that are within the resource standards of the federal supplemental security income program.

(g) The person is a qualified pregnant woman or child as defined in 42 U.S.C. 1396d(n).

(2) The department may establish income and resource limitations. Limitations of income and resources must be within the amounts permitted by federal law for the medicaid program.

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

(a) has income that does not exceed income standards as may be required by the Social Security Act; and

(b) has resources that do not exceed standards that the department determines reasonable for purposes of the program.

(4) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and similar costs for health insurance or other available health coverage, as provided in 42 U.S.C.

1396b(a)(1).

(5) In accordance with waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department of public health and human services may grant eligibility for basic medicaid benefits as described in 53-6-101 to an individual receiving FAIM financial assistance, as defined in 53-4-702, as the specified caretaker relative of a dependent child under the FAIM project and to all adult recipients of medical assistance only who are covered under a group related to the program of FAIM financial assistance. A recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage, as provided in 53-6-101.

(6) The department, under the Montana medicaid program, may provide, if a waiver is not available from the federal government, medicaid and other assistance mandated by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, and not specifically listed in this part to categories of persons that may be designated by the act for receipt of assistance.

(7) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 42 U.S.C. 1396a(l)(2)(A)(i), and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.

(8) Subject to appropriations, the department may cooperate with and make grants to a nonprofit corporation that uses donated funds to provide basic preventive and primary health care medical benefits to children whose families are ineligible for the Montana medicaid program and who are ineligible for any other health care coverage, are under 19 years of age, and are enrolled in school if of school age.

(9) A person described in subsection (7) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

~~(10) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households not eligible for medicaid with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department. The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce~~

~~countable family income in determining eligibility. The department may also adopt rules establishing fees, premiums, or copayments to be charged recipients for services. The fees, premiums, or copayments may vary according to family income.~~"

Section 4. Section 53-6-701, MCA, is amended to read:

"53-6-701. Policy of medicaid managed care -- system for integrated health care services. It is the public policy of the state of Montana to adopt, to the extent practicable, a health care ~~program~~ system that encourages the integration of health care services and that manages the health care of ~~program~~ enrollees to improve their health while preserving reasonable choice within a competitive and cost-efficient environment. In furtherance of this public policy, the department shall develop and implement ~~an~~ integrated health care ~~program~~ programs consistent with the provisions of this part. The provisions of this part apply only to ~~the program~~ programs created under this part. The department shall by rule identify persons eligible for enrollment in ~~the~~ a program. The department shall inform enrollees of their choice, if any, among health care delivery systems. Persons enrolled in ~~the~~ a program may also be offered cost-effective indemnity insurance plans, subject to availability."

Section 5. Section 53-6-702, MCA, is amended to read:

"53-6-702. Definitions. As used in this part, the following definitions apply:

~~(1) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.~~

~~(2)~~(1) "Department" means the department of public health and human services.

~~(3)~~(2) "Health maintenance organization" means a health maintenance organization as defined in 50-5-101.

~~(4)~~(3) (a) "Managed care community network" or "network" means an entity, other than a health maintenance organization, ~~that is owned, operated, or governed by a person and~~ that provides or arranges ~~managed~~ for comprehensive physical or mental health care services under a contract with the department ~~to enrollees of the program.~~, that is reimbursed by a capitated rate or a fixed monetary amount for a specified time period with a risk of financial loss or a financial incentive to the entity, and that:

(i) contracts for an estimated annual value of $1 million or more of state and federal medicaid funds; or

(ii) operates statewide or covers 20% or more of the medicaid population.

(b) The term does not include a provider of health care services under a contract with the department on a fee-for-service basis.

~~(5)~~(4) "Managed health care entity" or "entity" means a health maintenance organization or a managed care community network.

~~(6) "Person" means:~~

~~(a) an individual;~~

~~(b) a group of individuals;~~

~~(c) an insurer, as defined in 33-1-201;~~

~~(d) a health service corporation, as defined in 33-30-101;~~

~~(e) a corporation, partnership, facility, association, or trust; or~~

~~(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.~~

~~(7)~~(6)(5) "Program" means an element of the integrated health care ~~program~~ system created by this part."

Section 6. Section 53-6-703, MCA, is amended to read:

"53-6-703. Managed care community network. (1) A managed care community network shall comply with~~:~~

~~(a) the licensure and financial solvency requirements of Title 33, chapter 31, but the commissioner may by rule reduce or eliminate a requirement of Title 33, chapter 31, if the requirement is demonstrated to be unnecessary for the operation of the managed care community network; and~~

~~(b)~~ the federal requirements for prepaid health plans as provided in 42 CFR, part 434.

(2) A managed care community network may contract with the department to provide any combination of medicaid-covered health care services that is acceptable to the department.

(3) ~~A~~ The department, prior to entering into a contract, shall require that a managed care community network ~~shall~~ demonstrate to the ~~commissioner~~ DEPARTMENT its ability to bear the level of financial risk ~~of~~ being assumed by servicing enrollees under ~~the program~~ a contract for comprehensive physical or mental health care services. The ~~commissioner~~ DEPARTMENT shall by rule adopt criteria for assessing the financial ~~soundness~~ solvency of a network. The rules must consider risk-bearing and management techniques and protections against financial insolvency, if a managed care community

network is declared insolvent or bankrupt, as determined appropriate by the ~~commissioner~~ DEPARTMENT. The rules must also consider whether a network has sufficiently demonstrated its financial solvency and net worth. The ~~commissioner's~~ DEPARTMENT'S criteria must be based on sound actuarial, financial, and accounting principles. The ~~commissioner~~ DEPARTMENT is responsible for monitoring compliance with the rules. THE DEPARTMENT SHALL PROVIDE FOR INDEPENDENT REVIEW OF ANY CONTRACT PROVISIONS AND CONTRACT COMPLIANCE WITH THE FINANCIAL SOLVENCY RULES.

(4) A managed care community network may not begin operation before the effective date of rules adopted by the ~~commissioner~~ DEPARTMENT to implement the changes made by [this act] under this part, the approval of any necessary federal waivers, and the completion of the review of an application submitted to the ~~commissioner~~ DEPARTMENT. The ~~commissioner~~ DEPARTMENT may charge the applicant an application review fee for the ~~commissioner's~~ DEPARTMENT'S actual cost of review of the application. The ~~fees~~ fee must be adopted by rule by the ~~commissioner~~ DEPARTMENT. Fees collected by the ~~commissioner~~ DEPARTMENT must be deposited in an account in the special revenue fund and are statutorily appropriated, as provided in 17-7-502, to the ~~commissioner~~ DEPARTMENT to defray the cost of application review.

(5) A health care delivery system that contracts with the department under the program may not be required to provide or arrange for any health care or medical service, procedure, or product that violates religious or moral teachings and beliefs if that health care delivery system is owned, controlled, or sponsored by or affiliated with a religious institution or religious organization but must comply with the notice requirements of 53-6-705(4)(c).

~~(6) The commissioner shall adopt rules to protect managed care community networks against financial insolvency. Managed care community networks are subject to health maintenance protections against financial insolvency contained in 33-31-216 in the event that a managed care community network is declared insolvent or bankrupt.~~"

Section 7. Section 53-21-701, MCA, is amended to read:

"53-21-701. Mental health managed care allowed -- contract ~~-- advisory council~~. (1) ~~The department of public health and human services shall incrementally develop managed care systems for recipients of public mental health services.~~ The department of public health and human services may contract with one or more persons for the management of comprehensive mental health services for medicaid recipients, as provided in 53-6-116, and for persons ~~as specified in 53-6-131(10)~~ in households

not eligible for medicaid with family income that does not exceed ~~200%~~ ~~150%~~ 160% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department. ~~The department may contract for the provision of these services by means of a fixed monetary or capitated amount per recipient.~~ The department shall determine whether or not a potential contractor that will serve medicaid enrollees is a managed care community network, as defined in 53-6-702, prior to entering into a contract and shall ensure that each contractor that ~~assumes risk is required to comply~~ qualifies as a managed care community network complies with the provisions of Title 53, chapter 6, part 7, for the medicaid portion of the program.

(2) A managed care system is a program organized to serve the mental health needs of recipients in an efficient and cost-effective manner by managing the receipt of comprehensive mental health care and services for a geographical or otherwise defined population of recipients through appropriate health care professionals. The management of mental health care services must provide for services in the most cost-effective manner through coordination and management of the appropriate level of care and appropriate level of services. ~~The managed care system shall review and determine the appropriate level of services on an individual basis in order to ensure that access to care, quality of care, and the cost of the program are maintained.~~

(3) The department may enter into one or more contracts with a managed health care ~~entities~~ entity, as defined in 53-6-702, for the administration or delivery of mental health services. These contracts may be based upon a fixed monetary amount or a capitated amount ~~per~~ for each individual, and a contractor may assume all or a part of the financial risk of providing and making payment for services to a set population of eligible individuals if the contractor has complied with Title 53, chapter 6, part 7. The department may require the participation of recipients in managed care systems based upon geographical, financial, medical, or other factors that the department may determine are relevant to the development and efficient operation of the managed care systems. Any contract for delivery of mental health care services that includes hospitalization or physician services, or both, must include a provision that, prior to final award of a contract, a successful bidder that serves adults shall enter into an agreement regarding the Montana state hospital and the Montana mental health nursing care center that is consistent with 53-1-402, 53-1-413, and 90-7-312 and that includes financial incentives for the development and use of community-based services, rather than the use of the state institutional services.

~~(4) The department may establish eligibility requirements, resource and income standards,~~

~~premiums, fees, and copayments. Eligible individuals may not have a family income that exceeds the amount established pursuant to 53-6-131(10).~~

~~(5) The department shall establish the amount, scope, and duration of services to be provided under the program. The services to be provided and eligibility requirements may be more limited than those in the medicaid program under chapter 6.~~

~~(6) (a) The department shall form an advisory council, to be known as the mental health oversight advisory council, that is not subject to 2-15-122 to provide input to the department in the development and management of any public mental health system. The advisory council membership must include:~~

~~(i) one-half of the members as consumers of mental health services, including persons with serious mental illnesses who are receiving public mental health services, other recipients of mental health services, former recipients of public mental health services, and immediate family members of recipients of mental health services; and~~

~~(ii) advocates for consumers or family members of consumers, members of the public at large, providers of mental health services, legislators, department representatives, and a representative of the commissioner of insurance.~~

~~(b) The advisory council under this section may be administered so as to fulfill any federal advisory council requirements to obtain federal funds for this program.~~

~~(c) Geographic representation must be considered when appointing members to the advisory council in order to provide as wide a representation as possible.~~

~~(d) The advisory council shall provide a summary of each meeting and a copy of any recommendations made to the department to the legislative finance committee and any other designated appropriate legislative interim committee. The department shall provide the same committees with the department's rationale for not accepting or implementing any recommendation of the advisory council.~~

~~(7)~~(4) The department shall formally evaluate contract performance with regard to specific outcome measures. The department shall explicitly identify performance and outcome measures that contractors are required to achieve in order to comply with contract requirements and to continue the contract. The contract must provide for progressive intermediate sanctions that may be imposed for nonperformance. The contract performance evaluation must include a section concerning contract enforcement, including any sanctions imposed along with the rationale for not imposing a sanction when the imposition is authorized. The evaluation must be performed at least annually."

Section 8. Section 53-21-702, MCA, is amended to read:

"53-21-702. Mental health ~~managed~~ care -- system ~~elements~~ -- eligibility -- services -- advisory council. (1) The department of public health and human services shall develop a delivery system of mental health ~~managed~~ care from ~~current~~ providers or other entities that are able to provide administration or delivery of mental health services. ~~A system of mental health managed care must include the following elements~~ The public mental health care system shall:

(a) include specific outcome and performance measures for the administration or delivery of a continuum of mental health services ~~in order to provide contract compliance monitoring~~;

~~(b) a fixed monetary or capitated payment mechanism;~~

~~(c)~~(b) ~~a provision~~ provide for local advisory councils that shall report to and meet on a regular basis with the advisory council provided for in ~~53-21-701(6)~~ subsection (4);

~~(d)~~(c) ~~provisions for appeal at the local level~~ provide level-of-care appeals that are understandable and accessible; and

~~(e) a requirement that each contractor that assumes any financial risk shall comply with the provisions of Title 53, chapter 6, part 7, for the medicaid portion of the program;~~

~~(f) provisions that require documentation of evidence of the ability to provide services through an adequate provider network, as provided for in Title 33, chapter 36, and to comply with rules, regulations, and contract requirements;~~

~~(g) a provision that, prior to final award of a contract, a successful bidder that serves adults shall enter into a contract with the Montana state hospital and the Montana mental health nursing care center that is consistent with 53-1-402, 53-1-413, and 90-7-312 and that includes financial incentives for the development and use of community-based services, rather than the use of the state institutional services;~~

~~(h) the services that must be provided for medicaid-eligible individuals;~~

~~(i) a provision to allow a spenddown by individuals to become eligible for medicaid;~~

~~(j) the services, which may include a pharmacy benefit, that must be provided to nonmedicaid-eligible individuals whose income levels are below 200% of the federal poverty level as provided for in 53-6-131(10);~~

~~(k) a provision that allows implementation of a specific sliding scale for premiums or copayments by nonmedicaid-eligible individuals taking into account income and percentage of poverty level;~~

~~(l)~~(d) ~~a provision for~~ provide a system for tracking children who need mental health services that are provided under substantive interagency agreements between state agencies responsible for addictive and mental disorders, foster care, children with developmental disabilities, special education, and juvenile corrections~~; and~~

~~(m) requirements to ensure that the mental health managed care system will be operated in a cost-effective manner~~.

(2) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards of eligibility for mental health services may provide for eligibility for households not eligible for medicaid with family income that does not exceed ~~200%~~ ~~150%~~ 160% of the federal poverty threshold or that does not exceed a lesser amount determined at the discretion of the department. The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees, premiums, or copayments to be charged recipients for services. The fees, premiums, or copayments may vary according to family income.

~~(2)~~(3) The department shall establish the amount, scope, and duration of services to be provided under the program. Services for nonmedicaid-eligible individuals may be more limited than those services provided to medicaid-eligible individuals. Services to nonmedicaid-eligible individuals may include a pharmacy benefit.

~~(3) The department shall contract with an independent professional consulting firm that is knowledgeable and experienced in developing managed mental health care systems. The department shall require, as part of the contract, that the consulting firm make regular reports to the legislative finance committee and any other appropriate legislative interim committee. Reports must be made at least every 6 months and must include information about the development and implementation of the new mental health managed care system.~~

~~(4) The term of a mental health managed care contract may not be more than 5 years. The department may implement care-managed fee-for-service reimbursement to provide mental health services as otherwise permitted by law during the transition from a single statewide contract for mental health managed care.~~

(4) (a) The department shall form an advisory council, to be known as the mental health oversight

advisory council, to provide input to the department in the development and management of any public mental health system. The advisory council is not subject to 2-15-122. The advisory council membership must include:

(i) one-half of the members as consumers of mental health services, including persons with serious mental illnesses who are receiving public mental health services, other recipients of mental health services, former recipients of public mental health services, and immediate family members of recipients of mental health services; and

(ii) advocates for consumers or family members of consumers, members of the public at large, providers of mental health services, legislators, AND department representatives~~, and a representative of the commissioner of insurance~~.

(b) The advisory council under this section may be administered so as to fulfill any federal advisory council requirements to obtain federal funds for this program.

(c) Geographic representation must be considered when appointing members to the advisory council in order to provide the widest possible representation.

(d) The advisory council shall provide a summary of each meeting and a copy of any recommendations made to the department to the legislative finance committee and any other designated appropriate legislative interim committee. The department shall provide the same committees with the department's rationale for not accepting or implementing any recommendation of the advisory council."

NEW SECTION. **Section 9. Repealer.** Section 53-21-704, MCA, is repealed.

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